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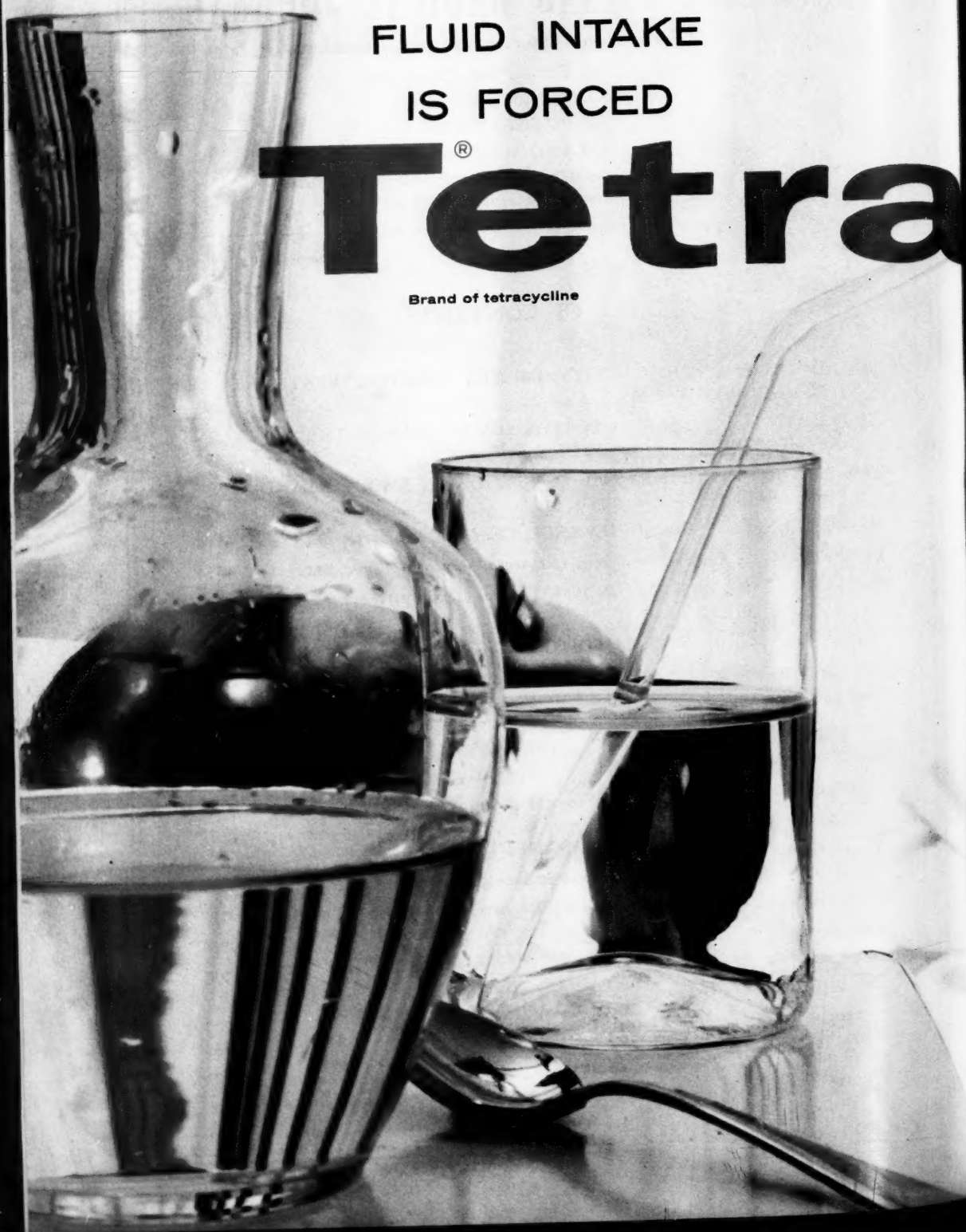
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## THE ADOLESCENT'S PERSONALITY: IMPLICATIONS FOR TREATMENT\*

J. ROSWELL GALLAGHER, M.D.

*The Author. J. Roswell Gallagher, M.D., of Boston, Massachusetts. Chief, the Adolescent Unit, Children's Medical Center; Assistant Clinical Professor of Pediatrics, Harvard Medical School; Author of "Understanding Your Son's Adolescence."*

SALLY WAS referred to our clinic for the management of what was said to be cardiovascular disease associated with tachycardia and hypertension. At examinations during the previous year she consistently had been found to have a heart rate of about 120 and a blood pressure of 150/90. There was nothing in this fourteen-year-old girl's history to suggest a familial, congenital or infectious cause of heart disease. She had no symptoms except palpitation and eye fatigue: it was the latter that had made her mother ask for a "check-up." There were no significant findings on physical examination, in the electrocardiogram, or on fluoroscopy of her heart. Nevertheless, on the basis of her blood pressure and pulse level, she had been told to give up all forms of exercise, and had been told she should "take it easy" all summer.

The following autumn, at her initial visit to us, Sally impressed her physician as being a healthy, strong, young person who would be quite attractive were she to lose her obvious air of resentment, suspicion and worry. Her physical examination and all the laboratory findings were in agreement with those reported at the time of her referral; but her pulse recovery after strenuous exertion was good, and neither her general appearance nor the findings seemed to us to justify a diagnosis of cardiovascular disease or to demand a restriction of her activities. As a matter of fact her physician's suspicion that other than structural changes were responsible for her borderline findings began as he formed an impression of her personality, and in-

creased as she told him things about herself, about her family, her friends, her daily life, plans, and her worries.

Sally's father, whom she adored, had been a fine athlete; she had always wanted to please him, to excel in athletics and become a physical education teacher. School work interested her very little. She wanted to be sure that studying wouldn't hurt her eyes, and the reading which the longer high school assignments required clearly worried her. She wasn't at all nervous at softball, in field hockey, or in a swimming meet, but she said, "My heart pounds when I have to give a talk in school." Her menarche the previous spring was a real blow: "Sure, I always wanted to be a boy."

There were enough hints here for anyone familiar with an adolescent's attachment to a parent, their hero worship, their resentment of anything that pushes them around, their frustration and worry when faced with something beyond their control and contrary to their hopes. Success, a career in athletics, was everything; becoming a woman was less than nothing. School work made her (eyes) tired, to talk in front of boys made her heart pound, and her periods "cramped her style." "I just got to worrying, — everything seemed wrong; boys never used to bother me, — nothing was working out right, and I just knew that the doctor would find something wrong and really spoil it all, and he did."

A big tomboy now, but still worshiping her father, and alternately envying boys and being conscious of them, she needed a chance to work out this confusion and to have unobtrusive support and understanding while she was making the transition to a more feminine approach to life. These she needed; and these, by paying attention to *her* and not to her heart rate, relieved them both.

It is not enough to know diseases, their causes, symptoms and treatment. It is equally important to know the person who has the disease, to know his or her characteristics, attitudes, needs and worries. These affect, and may even cause the symp-

*continued on next page*

\*From the Adolescent Unit, The Children's Hospital, Boston; Studies upon which this material is based have been supported by The Grant Foundation, Inc. Address presented at the Annual Meeting of School Physicians of Rhode Island, at Providence, R. I., May 4, 1955.

toms; they will modify the ailment's course. They obviously should strongly influence our thinking in making the diagnosis, and in choosing the method of treatment.

This is of course the proper way to regard all illness and all patients. But it is imperative in the management and treatment of adolescents. There is no other age group whose care furnishes so good an opportunity to supplement one's training in medical thinking with practice in being thoughtful. An adolescent's nature forces this opportunity on us. No other age group so insistently demands that you pay attention to the person as well as to the ailment. This stems from one of the adolescent's outstanding personality traits: their unyielding over-concern with themselves. They are so intent on developing their own personalities and so alert to any efforts to force them into a mold, that it is impossible effectively to deal with them unless one recognizes this and pays just as much attention to *them* as one does to their symptoms. The adolescent so keenly feels the need to become himself, to develop his own personality, that he instinctively resists any suggestion which he feels will either warp, or threaten, or thwart his own development, or any move which he feels may impose your will on his. Though they are intent on protecting themselves, they vacillate in their capacity to be independent and to be themselves and therefore, often behave in a blustering fashion characteristic of insecure people of all ages. In caring for them we need to remember that they are more aware of themselves than an adult, and less able to compromise.

In the Adolescent Unit general practitioners, internists and pediatricians all work together caring for those young people who come to them for help with their lame backs, their indigestion, their cramps, their heart trouble, but the emphasis is just as much on helping and understanding the person as it is on treating the symptom or the disease. The Adolescent Unit's major interest is the development of physicians' understanding of adolescents' personalities and of their skill in managing their psychosomatic disorders. Each physician in the Unit is assigned to a psychiatrist who acts as teacher and supervisor for all problems in diagnosis, management and psychodynamics which any patient presents. Every effort is made to teach these physicians how to approach patient care from the psychodynamic point of view, to recognize and treat minor emotional problems; to recognize those emotional patterns which require a psychiatrist's skillful management, and to appreciate the emotional component that is part of every organic disorder.

In order that we may elicit the information we need and build the best sort of physician-patient relationship, we treat these young people in a dif-

ferent manner than one usually treats little children. We give them a place which is exclusively theirs, where there are neither little children nor adults as patients. We see their parents first, and preferably on a previous day so that a boy or girl will not be kept waiting while his parents talk. We see the boy or girl alone so that they may talk confidentially. We discuss our findings and possible ways of handling the situation with them. And we discuss school, their interests, and their relationships as well as matters which might seem to be more intimately related to the presenting problem. Basically we are sincerely trying to get to know this person and to make him feel that we are as interested in him as we are in his problem.

It is our aim to have the general practitioners, pediatricians and internists working in the Unit gain both an intellectual concept of emotions, as they relate to general medicine and to acquire those techniques of psychotherapy which they can use daily in the practice of medicine. Increased knowledge of the personality development of the adolescent enables the physician to utilize it in handling all his patients whether they have a purely emotional disturbance, a physical ailment or a mixture of the two. As we all know, a doctor-patient relationship becomes more and more effective as a physician acquires this psychotherapeutic attitude and learns to understand his patient as a person and not merely as a problem in diagnosis and treatment. We feel that such an approach is desirable with all patients and that it is essential if one is to be successful with adolescents.

As a basis for understanding adolescents one must know something of their physical characteristics. Admittedly, and this is important always to remember, they differ widely from one another, but they all follow the same general pattern of development and have for the most part similar needs and problems. No one matter is of more interest and concern to them, or more frequently affects their happiness and behavior, than their bodies. Therefore, facts about growth and development during this age period are important to know.

Little children and adults have slight emotional concern with their size. An eight-year-old child does not care how tall or mature he is, and a thirty-year-old adult does not as a rule become emotionally upset by the fact that his height is greater or lesser than his neighbor's. The adolescent, however, feels differently about the matter. Height, weight, and state of maturity all mean a great deal during these years. The adolescent who is not maturing as rapidly as his or her companions, the boy who is shorter, or the girl who is taller or more obese than usual, not only dislikes being different but may become emotionally upset fearing that she will keep on getting taller or that he or she will never mature.

Some of this over-concern with their own growth and size is due to adolescents' conservatism, to their desire to be like their associates. Some of it arises out of the fact that size is a factor in their athletics, in their social success, and in their acceptance by their own age group. Some of it develops because for years their parents, teachers, and physicians have expressed such great interest in their growth and have compared them to charts and to standards which children accept unquestionably and yet fail to understand or misinterpret. At times their over-concern and anxiety arises because they suspect that their masturbation in which they guiltily persist may be adversely affecting them.

Few adolescents are aware that wide variation from the average is compatible with normality: to most of them to vary from what is average is to be abnormal. They need to have some knowledge of average patterns of growth and to understand the fact that a variety of different states and rates of growth and development are normal.

Just as their bodies develop and change so do adolescents' interests and attitudes. When an adolescent was a baby his crib measured the limits of his world. Next his play pen, later his back yard and his own home held all he had to understand. Then, a boy, he entered that wonderful carefree time of climbing fences, teasing girls, collecting everything, rising early, yelling, and chasing cats—a time of shyness, despising soap, stuffed pockets, and insatiable appetite. Now he is an adolescent. Soap and girls are no longer ignored, a trouser crease is more important than a bulging pocket, his ten thumbs and tripping feet show intermittent promise of coordination; he sleeps late, and only when off guard or with his group shouts or lets himself go. A tennis racket has replaced the sling-shot, and a football the raucous "cops and robbers." Those are the little changes. The major ones are his wanting to be grown-up, his striving for acceptance by his group and for prestige, his rebellion against authority, his negating of his family and his loyalty to his gang, his idealism and his questioning of what he used to accept on faith, his interest in sex. And yet the adolescent's striving, his interests and his rebellion vacillate. He will let his first "glamorous date" wait while he shows an old friend a new rifle, and he will fear at the end of a hard-fought struggle for independence to accept the freedom and responsibility he has won.

Much of the turbulence of adolescence comes from their confusion over which parent to model their behavior on, with which to identify, just as was true of Sally. It would seem a simple matter of boys following father, and girls, their mother, but this matter of identification with the appropriate parent is one of the more disturbing processes of adolescence.

Adolescents become upset by matters that less frequently disturb younger or older people. In early adolescence they do not transplant well; they miss the old places and their old friends and find making new friends difficult. It is a time when they badly need to be accepted: they are breaking away from their parents, so increasingly turn for support from "their gang." Religion, an upset home (it doesn't take a divorce to do it), death, fallen heroes, sex, and the behavior of adults in general, confuse and disturb them, and they become disturbed in their efforts to become grown-up and independent. They need success, friends, and acceptance. They need strong, stable, warm adults to turn to, to imitate, and for support, but not for dominance. They need praise as much as they need censure.

Rebellion is characteristic of young people who find the transition from utter dependence to independence so difficult. It is so annoying that we all have to remind ourselves at times that conformity and attendant dependency, though less apt to disturb the peace, may in reality at times be less desirable and promise little but trouble for the rough days of adulthood which lie ahead. The adolescent's imperative need to achieve independence and the importance of fostering the gradual evolution of his behavior from the utter dependency of infancy toward the complete independence of adulthood cannot be overemphasized. As young people grow up, they should have increasing opportunities to venture and to become independent: these they now need as they formerly needed constant protection and support. To continue to protect them, to continually thwart their attempts to develop independence is to rob them of the strength they will need.

During these years of beginning to be an adult, which is what adolescence really is, young people are breaking away from their parents and turning away from home. They want to be, and they should become, independent. But as they vacillate between dependence and independence, and alternately lean on, cling to, and reject their parents and their gangs, so also do they turn to and imitate other adults. With these there are no close emotional ties, there is no embarrassment, it is easier to talk. This gives all physicians who care for them an opportunity which should not be lost. The physician who understands adolescence and who is able to detect and treat minor emotional problems is in a position to do something at their onset: the time we all know they are most effectively helped.

Billy was brought into our Unit because he was stealing money, staying away from home until the early hours of the morning, and being truant from school. His mother said that his behavior had become increasingly rebellious over the past six years. He was the only child of parents who were divorced

*continued on next page*

when he was two and a half years old, and had been brought up by his mother.

At his first visit this twelve-year-old boy was extremely rebellious and demanding. He said that the only thing he wanted was a black leather jacket. "That's all I want." He talked about his stealing episodes, said that he just didn't know why he did these things, and spoke with much emotion of his mother's continual nagging and criticism. Billy talked, too, about his father, and ventured the opinion that his father was timid and drank too much. Toward the end of the visit he repeated his wish for a black leather jacket, and said he also wanted to be sixteen years old and to own a car.

As a rule the patient and his mother are seen together at the end of the initial interview. At this one there was a very unpleasant scene in which Billy was rebellious and resentful and made imperious and violent demands on his mother. His allowance wasn't enough; he couldn't go to the movies in town often enough; she wouldn't give him a black leather jacket. "Doctor, why don't you force her to give me a black leather jacket?"

Billy was subsequently seen several times within a month. During this time his behavior changed rapidly. He became talkative and friendly; and since his school was nearby, he would often drop into the Unit just to get a drink of water or come in to talk for only a few minutes. He has been seen approximately at monthly intervals for the past year and a half in this unusual fashion. There has been no unacceptable behavior, his school work is excellent, and the report from his summer camp was extremely complimentary.

Billy, like many an upset adolescent, was hungry to find a stable adult whom he could admire, imitate a little, lean on when necessary. Lacking a strong father he was confused about the business of growing up to be a man, and concurrently had to reject any tendency to be feminine by trampling on his mother. When such a boy fastens himself on an understanding physician, his behavior can change in a very gratifying manner.

Not all emotional disorders in adolescents respond promptly to short-term psychotherapy. This age group has its quota of schizophrenias, anorexia nervosas, and other grave psychopathies that require treatment by specialists. But many emotional disturbances whether alone or concomitant with an organic disease are amenable to treatment by the general practitioner, pediatrician and internist who has had some special training. Experience and training in the management of these minor emotional illnesses also familiarize the physician with the nature of adolescents' disturbances so that when he meets a more serious mental disorder he is far more likely to recognize it as requiring intensive treatment.

It is perhaps hardly necessary to state that we do not consider that these young people have been "cured." But they have been helped sufficiently so that they can lead effective lives. That goal may seem to some short of desirable, but we would not agree.

Sally's story illustrated the fact that a strictly medical approach can fail to help the patient, and Billy's how readily some adolescents respond and how their tendency to imitate and fasten upon a stable, warm adult can be utilized. Adolescents, however, will be best cared for when a knowledge of the personality is combined with a thorough knowledge of their physical ailments. It can be just as disastrous to focus upon a patient's emotions as it is to confine one's thoughts to what are sometimes unfortunately regarded as "strictly physical" illnesses.

Edith complained of nervousness, fatigue, inability to sleep, and recent failure in school. Her mother had taken this sixteen-year-old girl to several psychologists because she believed her symptoms were psychological in origin. Their findings showed that hostility toward her mother, and her mother's recent hospitalization for a ruptured disc were responsible for her present symptoms. They recommended psychotherapy.

Our patient was tall, attractive, and alert. She talked freely and without tension. Though she seemed to believe she had many things the matter with her, her manner of talking about them was that typical of a well-adjusted girl and not at all that of a neurotic person. Her interpersonal relationships seemed satisfactory, and her general demeanor seemed inconsistent with a psychosomatic disorder.

Her physical appearance, however, produced an impression in striking contrast to that gained of her personality, and subsequently her physical examination and her laboratory tests confirmed the initial clinical impression of hyperthyroidism. In this instance, had the physician not been familiar with adolescents, or had disregarded the emotional and physical aspects of his patient's disability, he might very well have overlooked the inconsistencies between the patient's behavior and her symptoms.

Edith's story clearly indicates that a knowledge of the adolescent's personality and a due regard for both the physical and the emotional factors in illness and the relationship between them are essential if one is to avoid erroneous diagnoses and unsuitable treatment.

It is at times a problem to get an adolescent to visit a clinic or a physician: even more frequently it is difficult to get him to accept help from a psychiatrist. In a medical clinic we have at our disposal a greater number of maneuvers which serve as rea-

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## RECOGNITION OF INJURIES TO THE LOWER END OF THE COMMON DUCT

ANTHONY V. MIGLIACCIO, M.D.

The Author, Anthony V. Migliaccio, M.D., of Providence, R. I. Surgeon, Rhode Island Hospital.

THE RECOGNITION of injury to the intrapancreatic portion of the common duct during manipulative procedures has been speculative. Rarely, does one hear it mentioned in the literature or in the operating room. This is in sharp contrast to what is known and written about injuries to the suprapancreatic portions of the common duct.

Recently, while trying to evaluate the condition of a common duct by the use of the Methylene Blue technique,<sup>1</sup> it was noted that the entire region behind and to the right of the duodenum had become discolored.

The presence of a false passage was thus recognized and another useful addition to the surgical armamentarium was established.

### Case History

Mr. M. DiC., age 52 (RIH #533600) was admitted to the Rhode Island Hospital on October 6, 1954, because of recurrent attacks of gallstone colic and several bouts of jaundice. He had been studied by both the Lahey Clinic and a local roentgenologist.

Following admission, a cholecystectomy and choledochotomy were performed. During the operative procedure, it was noted that the head of the pancreas was markedly indurated. This made palpation and exploration of the lower end of the common duct unsatisfactory.

Number three and four Bake dilators were readily and easily passed. The number five and number six dilators were missing from the setup. Rather than jump from a number four to a number seven, I decided to insert a catheter and inject Methylene Blue, in order to put this technique to the test.

When the Blue was injected, no dye could be recovered from the Levine tube lying in the duodenum. The retractors were removed and it was noted that the entire retroduodenal area was discolored.

It was decided to be conservative and to insert a T-tube into the common duct. The gall bladder had been removed previous to the exploration of the common duct.

The postoperative course was benign and the

temperature never went over 100. A cholangiogram, taken on the tenth postoperative day, was normal and showed no evidence of residual stones or extravasation.

The patient was discharged on his eleventh postoperative day and the T-tube was removed in my office on the twenty-first postoperative day.

Having established the fact that a false passage is present, one is then confronted with the question of whether further manipulations should be carried out. It is quite probable that transduodenal exploration of the lower end of the common duct or further intraductal manipulations of the distal segment will only serve to aggravate the existing trauma and, because of this, one should consider seriously whether it would not be wiser to terminate the procedure for the time being.

The dangers of continuing the exploration in the presence of a false passage lie in the fact that further manipulation will, in all probability, increase the trauma and therefore allow for the escape of a large amount of bile and pancreatic secretion into the retroduodenal area. The chemical reaction, thus initiated can be responsible for extensive retroperitoneal fat necrosis with its inevitable associated toxemia.

In contrast, if T-tube drainage is resorted to without increasing the amount of damage, then time will heal the injured common duct, thus avoiding extensive edema, infection and prolonged spasm of the sphincter of Oddi. The absence of these will make the handling of the obstructing calculus easier at a later date and at times we may be astonished to learn that the obstruction was probably due to infection and edema and not to a calculus at all.

### SUMMARY

The Methylene Blue technique offers us a new method of ascertaining the presence or absence of a false passage in the common duct.

After a false passage has been created and recognized, one must consider terminating further manipulation in order to avoid more extensive injury to the common duct.

### REFERENCE

- 1 Migliaccio & Dziob: A Simple Test to Determine the Patency of the Common Duct, Surgery, Vol. 36, No. 5, P. 953, Nov., 1954



## THE BEGINNINGS OF MEDICAL EDUCATION IN RHODE ISLAND

## Part I

SEEBERT J. GOLDOWSKY, M.D.

The Author. *Seebert J. Goldowsky, M.D., Surgeon, Miriam Hospital, Assistant Surgeon, Rhode Island Hospital, Providence, Rhode Island.*

THE MEDICAL HISTORY of Rhode Island is long and honorable. This account will be concerned largely with the education of doctors during the first two centuries, culminating in the establishment and eventual demise of the medical school at Brown University.

The first physician to join the colony was Doctor John Clarke who came to Portsmouth from Boston in 1638 and participated prominently in the founding of Newport in the following year. He had studied both medicine and theology at Leyden. In 1651 he returned to England with Roger Williams. During the succeeding twelve years he practiced medicine in London, devoting himself diligently in the meantime to the procurement of a new charter for Rhode Island. Following his return to Newport he officiated as pastor of the Baptist Church and practiced medicine until his death in 1676 in his sixty-eighth year.

The first medical degree awarded in Rhode Island and possibly anywhere in the colonies was conferred by the General Assembly, meeting in Newport on March 1, 1664, on Captain John Cranston. This was one of its first acts after receiving the Charter of 1663 previously referred to. John Cranston later became governor of the colony. It is well to review once again for the benefit of a new generation this quaint but important document:

"Whereas the Court have taken notice of the great blessing of God on the good endeavors of Captayne John Cranston of Newport, both in phisicke and chirurgery, to the great comfort of such as have had occasion to improve his skill and practice, &c. The Court doe therefore unanimously enacte and declare that the said Captayne John Cranston is lycensed and commissioned to adminester phisicke, and practice chirurgery throughout this whole Collony, and is by this Court styled and recorded Doctor of phisick and chirurgery, by the authority of this the Generall Assembly of this Collony."

About 1752 there arrived in Newport one Doctor William Hunter, a graduate of Edinburgh University, a pupil of the elder Monro and in his youth

a surgeon's mate in the British Army. He was a cousin of the eminent brothers John and William Hunter of London. He is generally credited with having given the first systematic advertised public lectures on Anatomy and Surgery in the colonies. Doctor Benjamin Waterhouse wrote in 1824: "About the year 1756, Dr. William Hunter, . . . 'clarum et venerabile nomen' gave at Newport, R. I. the first Anatomical and Surgical Lectures ever delivered in the twelve colonies. They were delivered in the court-house two seasons in succession by cards of invitation, and to great satisfaction. His collection of instruments was much larger than any professor exhibits at this day. Dr. Hunter was a man of talents, well educated at Edinburgh and a gentleman of taste in fine arts. He practiced from the time of his public lecturing at R. I. till the British occupied it, and died a hospital surgeon in their service." He wrote further: "It should be born in mind, that when Dr. William Hunter taught publicly Anatomy and Surgery at Rhode-Island, the Medical School at Philadelphia was not in existence. . . . The Hon. William Hunter, now senator in Congress, is the son of the respectable physician just mentioned, and who has recently presented some valuable books belonging to his father's library, to that of the college of Rhode-Island at Providence [i.e. Brown University]." This collection of books at Brown University, first assembled and photographed by Doctor E. B. Krumbhaar for his scholarly account of Doctor Hunter, published in 1935, is now being maintained intact at the John Hay Library.

These lectures, which actually were delivered during the winters of 1754-55 and 1755-56, were advertised on several occasions in the BOSTON EVENING POST during January and February of 1755. He is credited also with being the first male accoucheur, i.e. obstetrician, in the colony. In 1761 he married the beautiful Deborah Malbone, daughter of the socially prominent Colonel Godfrey Malbone and aunt of Edward Greene Malbone, the talented miniaturist and artist.

He served as surgeon to Rhode Island troops during several campaigns against the French in the years 1755-1758, under both Abercrombie and Amherst, eventually being commissioned Surgeon General by the General Assembly. He proved in the end, however, to be an unreconstructed Tory and

succumbed to fever while attending troops in a British Army hospital in Newport during the occupation of that town in 1777, the forty-seventh year of his life.

Doctor John Halliburton who arrived in Newport in 1750, had been surgeon aboard a British frigate. He subsequently resigned his commission and married a daughter of the prosperous Brenton family. He died there in 1807. He is best known now for having been the first preceptor of Benjamin Waterhouse, who wrote of him and of Hunter: "We doubt whether Boston, New York or Philadelphia, ever had, at the same time, two practitioners of physic and surgery, better educated and more skillful than these two gentlemen."

Doctor Isaac Senter, also of this period in Newport, was a better patriot than the others and served in the field with Rhode Island troops as surgeon during the Revolution. He contributed several papers to European journals, and was according to Waterhouse, "quoted with approbation in Europe." Other scholarly and well-educated practitioners of the period were Doctors John Brett and Thomas Moffatt. The latter was a business associate of Gilbert Stuart's father in the snuff mill enterprise in South County.

The Waterhouse account of the Redwood Library is of considerable interest: "Sometime about the year 1754, Abraham Redwood, Esq. a judicious and opulent gentleman of the Society of Friends, founded the 'Redwood Library' and gave five hundred pounds sterling for books, to be purchased in London: which commission was judiciously and faithfully executed. The medical part of them were excellent. They were amply sufficient to give the medical student competent information of all that was then known in the English language, on Anatomy, Surgery, Chemistry and Botany, together with the history of drugs, and of their various preparations and uses, with the history of the progress of Physic from Hippocrates to Boerhaave."

### *End of Golden Age*

The golden age of Newport ended with the British occupation. Again we can do no better than quote the eloquent words of Waterhouse: "Suffice it to say, that before the Revolution, Newport was a large and flourishing town; that when it became an English garrison, the people of wealth and consequence quitted it, and the town of Providence rose on its ruins. Since then, that once beautiful spot resembles an old battered shield, long held up against the common enemy. The town of Providence has now become opulent, and got so far the start of Newport, as to be able always to keep it."

Before our change of scene we should pause briefly to consider the greatest of them all, Doctor Benjamin Waterhouse himself, whose major focus of activity was elsewhere, but who retained to the

end a great devotion and admiration for his native state.

Benjamin Waterhouse was born in Newport in 1753. His mother was a niece of John Fothergill, the celebrated London physician. He attended Dean Berkeley's School, where Gilbert Stuart was a fellow student. At the age of sixteen he began the study of medicine under Halliburton. Setting out for Europe on the last ship to escape from Boston in 1775, he went first to Edinburgh where he studied under Cullen, Black and Monro. After a period in London during which he lived and studied with Fothergill, he went on finally to Leyden, seat of the great Boerhaave and achieved his M.D. degree there. He was appointed, in 1782, at the age of twenty-nine, the first Professor of the Theory and Practice of Physic at The Harvard Medical School. In 1782 he was elected to the Board of Fellows of the College of Rhode Island [Brown University]. In 1784, the college faculty was strengthened by the appointment of two professors "both of whom engaged to give Lectures in their respective Branches, without any Expence [*sic*] to the College while destitute of an Endowment." They were Joseph Brown and Waterhouse. The latter served without pay from 1784 to 1791. His duties at Brown did not seriously interfere with his obligations at Harvard as the daily routine in the former was carried out by tutors. He is best known for the introduction into America of cowpox vaccination for small-pox, the material for which he obtained from Jenner himself.

He later wrote of Brown: "Its College or University, from very small beginnings, has attained a respectable standing, and is in a fair way of becoming eminent: and it may not be amiss to remark here, that the first lectures on Natural History, particularly in Mineralogy and Botany [*i.e.* his own], ever given in North America were delivered in the College of Providence, in the year 1784, or about three years earlier than they commenced at Cambridge."

Before proceeding I should like to indulge in a brief bibliographical digression. The materials

*continued on next page*

## **OBSERVATIONS.**

**MEDICAL LITERATURE OF RHODE-ISLAND,  
WITH A SKETCH OF SOME OF HER MOST EMINENT MEN.  
*Communicated for the Boston Medical Intelligencer.***

W.

*Cambridge, July, 1824.*

Fig. 1. Caption and ending of Waterhouse's important essay showing his identifying initial. (Courtesy of The Rhode Island Medical Society Library)

from Waterhouse quoted at length above come from his delightful essay titled: *Medical Literature of Rhode Island, with a Sketch of Some of Her Most Eminent Men*. This was published in the BOSTON MEDICAL INTELLIGENCER of August 3, 1824. It was signed merely "W., Cambridge, July 1824." I have found no reference to this original source dated after 1838, although much of the material has often been quoted and at least on one occasion incorrectly attributed.

Although the colony's cultural activities during the middle years of the eighteenth century were centered preponderantly in Newport, one foray into medical education in the town of Providence is worthy of note. Doctor David Vanderlight, a native of Holland and a graduate of Leyden, came to Providence about 1750, married Mary Brown, sister of the four potent Brown brothers and acquired a house on South Main Street. He ran an apothecary shop, and in addition gave the first known instruction hereabouts in anatomy. He received his students at his home. Since he died in 1755 it is possible that his course antedated that of Hunter in Newport. Among his effects were "1 case for an Anatomy, with bones." It has been stated by several authorities that he introduced into Rhode Island the technique used in Holland for separating spermaceti from its oil, a method used with great success by his brothers-in-law in the highly profitable manufacture of candles. Professor Hedges, however, in his careful studies of the Brown affairs has concluded that this claim is not well documented.

Interest in medical problems in that era of versatility was not confined to practitioners of medicine. Moses Brown, whose primary activity was in the commercial world, had a scientific bent not unlike that of his brother Joseph. Among his voluminous papers, now preserved in The Rhode Island Historical Society Library, are copious notes concerning his observations on cancer and yellow fever. His studies on yellow fever, which caused so much suffering and loss of life during the last decade of the eighteenth century, were directed both to its etiology and epidemiology. One of his lists of yellow fever victims contains the name of Doctor William Bowen, followed by the notation "Recovered."

Although there were in the colony and state throughout its early years a nucleus of well-educated physicians, a number of whom displayed M.D. degrees from European universities, it was, nevertheless, the usual custom for a physician to enter the profession through preceptorship for three or four years with some prominent practitioner. During such apprenticeship he was obliged to aid in the preparation of medicines, participate in the care of the sick and assist at minor opera-

tions. In return for these services he could expect instruction in the various branches of the medical art. The teacher gave the pupil, on leaving, a letter of recommendation which was his only credential. During the second decade of the nineteenth century, however, a feeling became prevalent that medicine should be treated as a science rather than as an outgrowth of intuition. It was as a result of this changing view that Brown University became interested in the establishment of a medical school during 1810 and 1811.

#### *Medical Department at Brown*

The charter of Rhode Island College which became Brown University in 1804, authorized it to "admit to and confer any and all the learned degrees which can or ought to be given and conferred in any of the colleges or universities in America." Several times under this authority the degree of doctor of medicine had been granted to physicians already prominent in the profession. The first honorary M.D. degree conferred by the college was bestowed in 1804 upon Doctor Solomon Drowne, a graduate of the class of '73 and a bachelor of medicine from the medical department of the College of Philadelphia, 1781. Similar degrees were conferred in 1812 upon Pardon Bowen, Class of '75, and Levi Wheaton, Class of '82. The medical school itself was formally established in 1811, thus becoming the third oldest in New England following Harvard founded in 1782 and Dartmouth in 1798. The only other schools in existence at the time were those associated with William and Mary, King's College (Columbia), Queen's College (Rutgers) and the college at Philadelphia (later the University of Pennsylvania).

The organization of the new school in September of 1811, during the administration of President Asa Messer, was consummated by the designation of the first three members of the faculty: Solomon Drowne, Professor of Materia Medica and Botany; William Ingalls, Professor of Anatomy and Surgery; and William Corlis Bowen, Professor of Chemistry. A committee of the Corporation was then appointed to select a suitable candidate to give lectures on the Theory and Practice of Physic. For its day this was a fairly strong faculty.

#### *Doctor Solomon Drowne*

Doctor Solomon Drowne, who was born in Providence in 1753, studied locally with Doctor William Bowen and later received his degree in medicine in Philadelphia, as previously mentioned. Following extensive and highly regarded service as a surgeon in the War he returned to Providence to set up in practice. He was appointed to the Board of Fellows of Brown University in 1783. Feeling the need for further education, however, he pulled up stakes and sailed for Europe in 1784, where he

assiduously attended lectures and visited hospitals in both London and Paris. While in the latter city he became intimate with both Thomas Jefferson and Benjamin Franklin, who were in France at the time. Returning to America in 1788 he lived for a while in Ohio, Virginia and Pennsylvania before returning at long last to his native Rhode Island in 1801. He bought an estate in Foster where he built a spacious residence to live out the remainder of his days in a sylvan setting immersed in nature and the rural life of which he was so fond. On the grounds surrounding his lovely new home, to which he gave the name Mount Hygeia, he developed the first botanical garden in the state. His extensive collection acquired fame and attracted visitors from great distances. The homestead still stands, though in a distressing state of deterioration. Its original charm, nevertheless, can still be felt. Title to the property, still residing with the Drowne heirs, is bogged down in almost insurmountable legal complexities, Doctor Drowne having left no will. Adequate funds to restore and maintain the property have not been available. Many of his papers, lectures, notes and letters, as well as the bulk of his personal library, are now in the possession of the John Hay Library having been donated by the family a number of years ago. More recently the remnants of his personal library were salvaged from the attic of the old house and were added to this collection. Doctor Drowne lies buried nearby in the family plot, his grave marked by an aged headstone which recounts in terse but dignified phrases the above biographical data.

Doctor Drowne was a very popular lecturer. Under his direction the students began on the college grounds a botanical garden, which was a source of considerable pride to him and which existed according to his own word at least until 1824. He was, it appears, better fitted for a life of contemplation and study rather than for the routine of medical practice. It has been said that if, on the way to visit a patient, he recognized an interesting botanical specimen, he would stop and perhaps spend the whole day in the fields or woods. A vice-president of the Rhode Island Medical Society, he was sent as a delegate to the convention that formed the National Pharmacopeia in 1819. In this connection the following notation in the minutes of the Society for September 5, 1820, are of interest: "Voted. That the collection of Fines and Taxes due from Solomon Drowne be suspended until his settlement with the Society for attendance at Boston as a member of the committee for forming a National Pharmacopoea [*sic*]." Three years elapsed before he finally "received \$25 from the Treasurer of the Society on acct of his attendance." Following the closing of the school, he lived on

another seven years, passing on in 1834, in his eighty-first year.

#### *Doctor William Ingalls*

Doctor Ingalls, although somewhat less colorful, was nevertheless a prepossessing figure. A graduate of Harvard in the Class of 1790, he received his bachelor of medicine in 1794 and his M.D. in 1801, both at his Alma Mater. His whole professional life was spent in Boston where he gained considerable prominence because of his skill as a surgeon and because of his early opposition to the practice of bleeding. He kept a private room for the study of anatomy as well as a museum of anatomical preparations in his home on School Street. In addition, he maintained an anatomical lecture room on Market Street, where he regularly met with his students, averaging as many as twenty-five to thirty. After his appointment at Brown in 1811, he lectured in Providence regularly until 1815. At that time he offered his resignation, feeling that the poor financial reward did not warrant his trips to Providence. For some time students were permitted to attend his lectures in Boston and were permitted to use the credits toward their degree. To help fill the gap, Doctor John Mathewson Eddy was appointed adjunct professor, but he died prematurely barely two years later. He was a founder of the Rhode Island Medical Society and was considered to be a man of considerable promise. It was written of him that he was "cut down in the midst of [his] usefulness, which should serve to remind us of the uncertain tenure of our own lives."

#### *Doctor William Corliss Bowen*

Doctor Bowen, the final member of the original triumvirate, was an only son of the eminent Doctor William Bowen. He was born in the family home at the foot of College Street in 1785. After matriculating at Rhode Island College, he transferred to Union College where he graduated in 1803. After commencing the study of medicine with his uncle, Doctor Pardon Bowen, he went on to Edinburgh, receiving his M.D. there in 1809 (or 1807). Following this, he studied also in Paris and in London where he was a private pupil of the great Sir Astley Cooper. He was a young man of brilliant attainments and yet at the same time had a kindness of manner which endeared him to his patients. As a diversion from his medical preoccupations he became engaged in extensive experiments with bleaching solutions. This activity laid the foundation for the bleaching industry which thrived for many years during the era of textile prosperity in Rhode Island. He died in 1815, his thirtieth year, of tuberculosis which was thought to have been aggravated by the prolonged exposure to chlorine vapor. "In the death of Dr. William C. Bowen," wrote Doctor Usher Parsons, "Rhode Island lost its brightest

*continued on next page*



ornament of the medical profession."

About this time there appeared in the form of a pamphlet dated August 18, 1815, "A Letter to the Corporation of Brown University, suggesting certain Improvements in its Academical System," signed merely "Alumnus Brunensis." As one who had "not been at all times wholly unconnected with the Institution, . . . and who still recollects with affection his alma mater," he begged "respectfully to offer a few reflections on its present situation, and on the possibility of its improvement."

"A Medical School complete in all its parts," he asserted, "and conducted with ability and zeal, is a most important portion of a University. Ours is incomplete. The departments of Chemistry, and of the Theory and Practice of Medicine, remain to be filled. And they must be filled. If it is designed that the school shall ever have extensive reputation, there is no excuse for the deficiency. Two able Professors fill the other departments. But will medical students extensively resort to a school 'but half made up,' when complete establishments are inviting their patronage on every side? It cannot be. . . . Unless a remedy be soon applied, it will become the established reputation of the School that it is essentially incomplete: and after such a reputation shall have become established, it will require many years of complete operation, should that event ever happen, to remove the injurious impression. . . . Not a moment ought to be lost in completing the establishment, especially since not a single serious obstacle appears to oppose its completion. There is certainly no possible difficulty in obtaining an able person for the department of the Theory and Practice of Medicine. And for that of Chemistry there is a gentleman within a few miles of the institution eminently fitted, could be induced to engage for the good of the College. . . ."

"To the department of Anatomy and Surgery also ought to be added that of Physiology. This subject is very important to medical students, while to general students it is by far the most interesting of all medical branches. . . ."

"The Lectures of the Professors should be aided by regular classical recitation. . . . Taking anatomy as the example, let the method be this. Let a concise text-book be adopted, comprising the principles of Anatomy: and let this be in the hands of each attendant. Let this text-book, as nearly as possible, guide the Lecturer in arranging his plan of Lectures. . . ."

These proposals were certainly pertinent and valid, although as pointed out by Professor Bronson, the need for laboratories and clinics was not sufficiently evident for them even to have been mentioned.

On another sore point, the writer continued as follows: "Another improvement in this department is very essential. On the present plan, the profes-

sors depend for compensation entirely on the fees of attendance. This gives them a most precarious standing. Repeatedly has it been the lot of a professor, as the season for his lectures approached, to visit the college, inquire how many attendants would be had, be informed that for this and that reason they would be very few, and return to his residence, lamenting that he must wait another year, because an unfortunate arrangement has made the discharge of his duties dependent on the accidental finances and feelings of fifty or sixty youth. This state of things is too humiliating. It has already occasioned the loss of one distinguished professor [Dr. Ingalls]. Let the evil be remedied. Let therefore a certain sum be annually paid from the treasury to each of the professors. . . ."

Whether or not the proposals vigorously outlined in this broadside were heeded, the fact is that shortly thereafter Doctor Levi Wheaton was appointed professor of the Theory and Practice of Physic and Doctor John M. Eddy was appointed to his brief tenure as adjunct professor of Anatomy and Surgery. The chair of chemistry, which had been vacated by the enforced retirement of Doctor Bowen in 1813, was not filled until 1817. Doctor John Mackie of Providence had been offered the post in 1815, but had declined. The new professor of chemistry was John DeWolf of Bristol.

#### *Doctor Levi Wheaton*

Doctor Wheaton, born in Providence in 1761, attended Rhode Island College from which he received his A.B. degree in 1782. His medical experience began as a volunteer in the Military Hospital in Providence in 1778. He studied medicine during the succeeding two years with Doctor Joshua Babcock of Westerly and Doctor William Bowen of Providence. After completing his medical studies he served as surgeon on board a privateer, from which he was taken prisoner by the British and brought to New York. He took charge for several months of the prison hospital ship *Falmouth*. At the end of the war he moved to Hudson, New York, which had been founded by settlers from Providence, and practiced there for ten years. He later removed to New York City where he practiced for about two years, returning to his native town about the turn of the century. He was elected a trustee of Brown University in 1789, serving in that capacity for the remainder of his life, and was awarded an M.D. by his alma mater in 1812.

Doctor Wheaton was described by a contemporary as a "thoroughly read and sound practical physician . . . entitled to preeminence: but . . . still more so . . . a man of erudition and general scholarship." He was solicitous for his patients and conscientious in their care. His lectures at the medical school were considered to be "very creditable to his talents." He was the author of medical papers on



yellow fever, on the use of calomel and on Asiatic cholera, and for a number of years contributed to the BOSTON MEDICAL AND SURGICAL JOURNAL over the signature, "Senex." Unlike his colleague, Doctor Ingalls, he was an enthusiastic exponent of phlebotomy in the treatment of disease. He served for many years as physician to the Marine Hospital at the Port of Providence, there being some implication that he utilized this clinical material in his teaching. After a long and fruitful life, he departed these realms in 1852 in his ninety-second year.

limited and imperfect,—hardly worthy of the name. It was understood that he used his own apparatus, which he brought with him, whenever he commenced a course of lectures and experiments. He had a very happy faculty of communicating the truths of the science to the youthful mind." He was sought after as a public speaker in the community because of his "finished rhetoric" and "sparkling wit" and he attained some renown as a poet. Following his departure from Brown he taught chemistry at the medical colleges at Woodstock and Castleton, Vermont, and later at the medical school at St. Louis. He subsequently retired to his native town where he passed on in 1862 at the age of 76.

*Doctor Usher Parsons*

Although the last remaining accession to the faculty of the school, filling the vacancy left by Doctor Eddy's untimely death, did not occur until 1822, we shall consider it before proceeding to other matters. The new incumbent of the chair of Anatomy and Surgery, Doctor Usher Parsons, was born in Alfred, Maine, in 1788. His medical studies, begun in 1807 in the office of Doctor Abiel Hall in his home town, were pursued at Fryeburg, Maine, under the tutelage of Doctor Alexander Ramsay, a skillful anatomist and stimulating lecturer. In 1811 he moved on to Boston "determined to obtain the degree of A.M. and M.D., and to become a teacher of anatomy." He entered the office of the eminent surgeon Doctor John Warren, a professor in the Harvard Medical School and brother of General Joseph Warren, himself a physician, who fell at Bunker Hill. Following completion of these studies he was examined by the censors of the Massachusetts Medical Society and was approved and licensed "a Practitioner in Medicine," on February 7, 1812. After several unsuccessful attempts to find a suitable location in which to practice and with the imminent prospect of war, he sought a naval commission. This was granted in July 1812. He saw distinguished service with Commodore Oliver Hazard Perry at the Battle of Lake Erie where he was, in fact, the only surgeon present due to the illness of two other medical officers assigned to that action. He served later in the Mediterranean Theater as well. In the course of time he rose in rank from surgeon's mate to surgeon. As a result of his highly successful treatment of the wounded at Lake Erie a citation was sent by Perry to the Secretary of the Navy and in addition he became Perry's close personal friend. Out of nearly one hundred wounded in the battle, he lost only three, a respectable figure even for this day. This was the beginning of his reputation as a surgeon.

While in the Mediterranean service he found time to visit medical centers at Naples, Palermo, Rome and Florence. After returning to New Eng-

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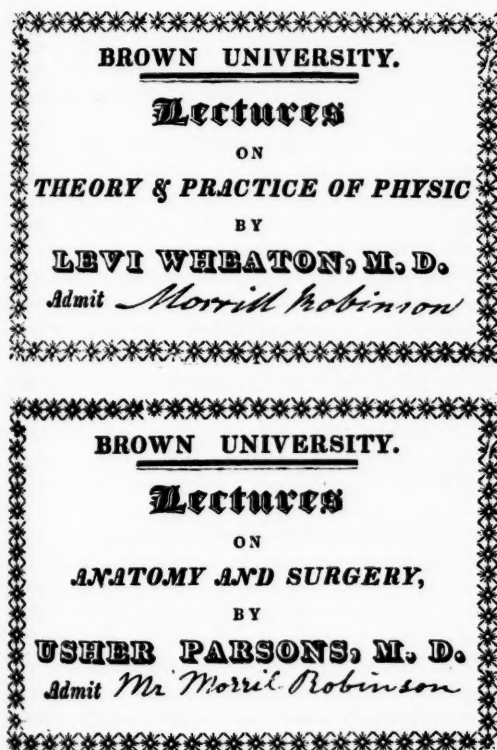


Fig. 2. Examples of tickets admitting students to Medical School lectures. (Courtesy of The John Hay Library, Brown University)

*Doctor John DeWolf, Jr.*

John DeWolf, Jr., great-grandfather of Doctor Halsey DeWolf, was born in Bristol, Rhode Island, in 1786. Although he matriculated at Brown, he did not graduate. He obtained his chemical education from the celebrated Doctor Robert Hare of Philadelphia, who later became professor of chemistry at the University of Pennsylvania. Considered to be a brilliant lecturer and experimenter, DeWolf served as professor of chemistry at the University for twenty years. A graduate of the class of 1826 who had attended the lectures wrote: "The chemical apparatus belonging to the college was very

land in 1817 he attended lectures at the Harvard Medical School, receiving there the degree of M.D. in March, 1818. In that same year he published (in the NEW ENGLAND JOURNAL OF MEDICINE AND SURGERY) his famous *Surgical account of the Naval Battle on Lake Erie*. During a subsequent naval cruise in Europe he sought for and was granted a leave of absence on account of his health. This gave him an opportunity to visit clinics in Italy, London and Paris. He took copious notes and bought many medical books and instruments.

Following his return to the States in 1820 he was chosen Professor of Anatomy and Surgery at Dartmouth, fulfilling at last his long-standing ambition. He served there, however, only one year. At this time he wrote and published *The Sailor's Physician*, which was to go eventually through five editions. He made an extended trip to the medical schools in New York, Philadelphia and Baltimore, attending lectures at all of them.

His long residence in Providence began in April, 1822, when he entered practice for a while as partner to Doctor Levi Wheaton. In the same year he married Mary Jackson Holmes, elder sister of the later famed Oliver Wendell Holmes. Oliver was thirteen at the time. Mary Parsons died in 1825, after only three years of marriage, leaving one son. She was, it appears, a charming and gifted woman. Correspondence between Oliver and Doctor Parsons covered a period of many years, during which Parsons served as confidant and advisor to Holmes both during his medical studies at Harvard and abroad. Many references to Parsons may be found in Holmes's published letters. A communication from Doctor Parsons to the curator of the Hunterian Museum in London was most helpful in getting Holmes an entree to that renowned institution. On one occasion while in Paris young Holmes bought two skeletons, one for himself, and a showy one for his brother-in-law, which he sent to him along with some "new-fangled instruments," some botanical plates and some medical texts.

Since the death of Doctor Eddy in 1817, the fortunes of the Medical School appear to have been at a low ebb. With the appointment of Doctor Parsons to the position of Adjunct Professor of Anatomy and Surgery in 1822, the school was "reorganized." Wrote his son, Doctor Charles W. Parsons: "A plan of giving lectures in Brown University, which had failed in 1817, was resumed in 1822." He wrote further: "The opening of courses by Doctor Parsons gave new life to the institution. He made arrangements, through channels over which a veil of secrecy had to be thrown, for a supply of anatomical material. He was the owner of valuable and novel representations of human structure in wax models made in Italy. He had learned from Doctor Ramsay the methods of displaying and preserving

the perishable organs." In 1831 he published a handbook titled *Directions for Making Anatomical Preparations*, which outlined the then current methods.

In 1823, he was promoted to professor and in the same year he resigned his commission in the navy. Although his academic career at Brown ended with the closing of the school barely four years later, he had a long and distinguished career in medicine in Providence. A bibliography of his writings published by his son comprised fifty-eight items, containing many historical as well as medical essays. On four occasions he won the Boylston prize for dissertations on medical subjects and in addition the Fiske Fund prize of the Rhode Island Medical Society. He prepared in 1826 a series of lectures on anatomy and physiology for the upper classmen at Brown and introduced it with an eloquent and forward looking exposition on "The Importance of the Sciences of Anatomy and Physiology as a Branch of General Education." A study titled "On the Administration of Medicines by the Veins; Being a Brief Inquiry into its Safety and Utility" appeared in 1828. This interesting investigation, employing animals (sheep) as subjects and a variety of pharmacotherapeutic materials (including arsenic), although producing discouraging results, nevertheless antedated the work of Ehrlich by almost a hundred years. He affirmed rather dogmatically "that the introduction of medicine by the veins can never be practiced with utility or safety, even in the few cases where, from obstructed deglutition, or other causes, they are inadmissible by the stomach." He was responsible also for a rather involved study published in 1830 "On the Comparative Influence of Vegetable and Animal Decomposition as a Cause of Fever." He concluded that either could be an effective cause. In a rather intriguing essay "On the Use of Alcohol in the Disease Produced by the Bite of the Rattlesnake," he opined that "the stimulus no doubt counteracted the poison." Much more highly perceptive was his "Lecture on the Connection and Reciprocal Influence Between the Brain and Stomach" which appeared in 1840. He was undoubtedly influenced by the monumental work of William Beaumont appearing between 1825 and 1833 to which he made reference. Wrote Parsons: "The nervous and dyspeptic complaints incident to adult persons, whose brain or instrument of the mind is constantly overexcited by emulation, ambition, anxiety, tribulation, and a thousand other causes, are constantly multiplying in frequency and intensity, with the increase of population, and with the march of intellect and refinement. The fury of politics, the jealousies, envyings and rivalries of professions, the struggles for office, the contentions of trade, the excitements of speculation, and the

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# The RHODE ISLAND MEDICAL JOURNAL

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## SOCIAL SECURITY AND THE MEDICAL PROFESSION

THE POSITION of the American Medical Association, speaking for the physicians of America, has been set forth on several occasions in recent years in the debates on the inclusion of doctors under the federal social security system. In June, 1949, the House of Delegates adopted a resolution strongly opposing compulsory coverage of physicians. In December, 1953, another resolution was adopted reaffirming the Association's support and endorsement of the *voluntary* pension program provided in the then Jenkins-Keogh bills, and its strong opposition to the extension of compulsory coverages under the Social Security Act.

In February, 1954, the Board of Trustees of the A.M.A. again reviewed this question and reaffirmed the Association's position of opposition to compulsory coverage, but the Board did determine that no objection would be raised to the extension of the Old Age and Survivors Insurance provisions of Title II so as to permit *voluntary* coverage of physicians.

There have been presented to Congressional committees many sound and valid reasons why physicians do not wish compulsory social security, basically because old age benefits under the program do not fit the economic pattern of the life of the self-employed physician. The A.M.A. has, to-

gether with many other organizations and individuals, asked for Congressional support of bills before the Congress that would provide a long-range plan for encouragement through tax deferments for self-employed people to set aside limited amounts from their earned income into restricted retirement annuity or pension trust programs from which they could draw benefits on attaining age 65.

The Rhode Island Medical Society, acting through its Council and House of Delegates whose daily contact with the membership of the Society guarantees a sound reflection of the views of the majority, has concurred with the action taken at the national level.

In some parts of the country, notably New York City, physicians have been vociferous in their statements that all physicians should be covered under the social security system on a compulsory basis. It is not known how these same physicians would vote if the proposal were to be subsequently advanced that for an additional tax the federal system add compulsory medical care to its program, and all doctors would then be indirectly government employees.

This spring our House of Delegates authorized the mailing of a ballot to each member with supple-

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mentary information giving factual data on a re-appraisal of social security. Every effort was made to inform the doctor that he might make his decision clearly and express his views without being influenced by any group. Ballot did not even require a signature, if the physician preferred not to make it.

The summary of the membership poll recently submitted to each of the district society secretaries indicated an overwhelming refusal by Rhode Island Medical Society members of compulsory social security coverage. Only 7.5% of those voting favored compulsory coverage, whereas 33% opposed any inclusion whatever, and less than one-third who favored voluntary coverage would go along with compulsory provisions if the government denied voluntary inclusion.

This clear-cut expression by the individual members of the Society on this important question indicates that our district societies have chosen as elected representatives on our policy making bodies physicians who have honestly reflected the opinion of their constituent association's membership in establishing state and thereby national policies affecting medicine.

Of all the local organizations with which we are familiar, we think we can state without fear of repudiation that ours operates as an outstanding democratic body that seeks what is best for the majority, whether that majority is the public in matters of public and general welfare, or a majority of our own membership when the issue is one that concerns us primarily and directly.

Our Council, composed of the five most recent living former presidents of the Society, the current officers, and a Councillor elected by each of the seven district societies, serves as a board of trustees to carry on the work of the Society throughout the year. The Council in turn is subject to the final decision of the House of Delegates, meeting regularly three times annually, and composed of one delegate for each twenty Fellows of the Society, said delegates to be elected by the component district societies on the basis of their active membership total.

#### COMMENDABLE COMMUNITY ACTION

We have read a good deal in recent years of the action of communities in some of our large rural states of the west and midwest in solving their physician needs by providing the facilities for a doctor to work in the area under the most favorable conditions. Here in the nation's smallest state, criss-crossed by four-lane highways and with no citizens more than twenty miles from a modern hospital, and certainly not that distance from a physician, the problem has been a minor one.

However, the development of suburban residen-

tial areas—and in our state suburban soon becomes semi-rural once beyond the perimeter of metropolitan Greater Providence, Pawtucket, Central Falls, Cranston and East Providence—has focused attention on the importance of a physician in residence in some of our formerly small communities. Charlestown, Richmond and Hopkinton tackled the problem of securing a physician a year or two ago as a tri-community action. Scituate has attracted a physician within the past year, and now Glocester, thirtieth ranking town by population status in the 1950 census, and claiming fifty-six square miles of jurisdiction, has shown how a community can secure a physician to meet its needs.

By forming a "doctor for Glocester committee" the residents of the town acquired support from residents to endorse bank notes guaranteeing a twenty thousand dollar loan for the construction of a combination residence and office building to house a physician and his family. Land was donated by the chairman of the committee, and in a relatively short time construction is scheduled to start. The community gesture was soon noted, and at this writing a physician and his wife, who is also a physician, both currently Providence residents, will establish their practice in the town taken from Providence 225 years ago and named from Frederick Lewis Duke of Glocester, son of King George II.

It is this type of community action that made our communities with their town meetings famous and independently progressive in the early years of New England's growth. It is the same type of community action that can solve many of the seemingly complex situations in this twentieth century.

#### INTERIM MEETING—OCTOBER 26

With the American Medical Association honoring New England for the first time in more than thirty years by holding one of its major scientific sessions in the area—the Interim Clinical Session is at Boston starting November 29—many local medical organizations are curtailing on their own meeting programs for the fall season.

We are pleased that the Committee on Scientific Sessions of our Society has voted to go ahead with the annual Interim Meeting, and we are doubly pleased upon reading the outstanding program that has been arranged, copy of which is published elsewhere in this issue of the JOURNAL.

A symposium on diseases of the colon by such an array of outstanding panelists as Claude Welch, Franz Ingelfinger, Richard Schatzki, all of Boston, and John Garlock of New York, promises one of the finest afternoons of clinical medicine that has been offered our membership in years. The decision to hold the meeting in Providence, and the scientific session at the Medical Library, should appeal



to everyone.

We have checked Wednesday, October 26 on our calendar as a *must* meeting to attend. We advise every member to do likewise.

### X-RAY BENEFITS ADDED

When the Blue Cross hospitalization program gained momentum twenty years ago, plans in some areas included such medical benefits as anesthesia and radiology. With the start of the Rhode Island Plan all parties concerned agreed that these medical benefits should not be included as hospital services, but that if and when the physicians of Rhode Island established a Blue Shield type of program the inclusion be left to that plan.

The start of Physicians Service in 1949 saw the realization of part of this decision made a decade previously, as anesthesia was included along with surgery and medical visits in the hospitals.

Now, with the Physicians Service program widely accepted, and with a desire to extend benefits in accordance with public requests, X rays and electrocardiograms have been added to the schedule of indemnities for a small additional premium. This step should certainly win popular approval in view of the wide use of radiological services in medical practice today.

Physicians Service has proceeded carefully in expanding its program in the best interests of the people whom it seeks to serve. A year ago the late Doctor Joseph O'Connell, then president of the Corporation, pointed out that the developments and expansion of benefits within the premium charge left little margin for emergencies, and none for extension of the program. Now, after six years of successful service, Physicians Service makes its first increase in the subscriber charges, and in so doing adds the important radiological coverage, both in and out of the hospital.

### N. E. HOSPITAL INTERNATIONAL PROGRAM

While cameras clicked in Geneva, Switzerland, recording an epochal meeting between the foremost leaders of the world for securing world peace, news reached our desk of another step being taken to further the cause of international amity through medicine. This step forward has not been heralded with as much publicity, true, but it interests us because it is initiated in Boston and since it is a medical "first," we feel it worthy of honorable mention.

The New England Hospital of Boston, Massachusetts has launched an international educational program for women physicians. Its aim is to provide advanced medical training and opportunities for women physicians of foreign countries who

wish to avail themselves of it to render better medical services to their own countrymen. The bulletin issued by the New England Hospital brings out the point that: "In this country only 6% of our medical students are women. In many other countries today the number ranges from 10% to 50%. . . . However while medical education is available to them in schools, there are not sufficient hospitals nor qualified staff and teachers to provide the advanced education in residencies and internships that is necessary to round out their experience and knowledge." The primary purpose of the New England Hospital Trustees and Staff in preparing a well-rounded all-comprehensive educational program for qualified women physicians from other countries is in "extending the frontiers of good medical care, throughout the world."

The New England Hospital, founded in 1862, pioneered in seeking greater opportunities for women in medicine at a time when their activities in this field were frowned upon. It has continued its chartered purposes and has created high levels of medical education and opportunity for women these past 93 years.

It is particularly fitting then it seems to us, that at this particular time—when there is so much need for greater international understanding, the New England Hospital should be the first to offer its advantages to medical women from foreign countries in a gesture of friendliness and thus spread the knowledge of American medicine to the confines of the earth.

*We feel that the action of the New England Hospital in broadening opportunities for training women doctors is an important one. So, we asked Dr. Vidal to review the matter and are very pleased to put in her remarks and also her accompanying letter to the editor which we feel has some very pertinent observations.*

— THE EDITOR

\* \* \*

Editor-in-Chief  
Rhode Island Medical Journal

Dear Editor:

I am not at all certain that I have treated this international program with sufficient enthusiasm. However I could not refuse your kind request to at least surrender mine humble opinion. I shall not be the least offended if you cannot accept it.

I invariably squirm when I anticipate or begin to hear pointless discussions on: men *vs.* women in the Medical Profession, and have never felt like carrying the torch unduly for my sex in the field. I believe it to be an individual and rather sacred matter, that of a man or woman's dedication to an ideal where percentage and per capita ratios between one sex and the other are hardly the measures of ability or success, nor the justification thereof.

Sincerely,  
JEANNETTE E. VIDAL, M.D.



# THE ADOLESCENT'S PERSONALITY: IMPLICATIONS FOR TREATMENT

*concluded from page 494*

sons for return appointments than does a psychiatric one. Patients who are at first reluctant to return often lose their initial resistance after the visits which additional medical or laboratory procedures require; or may be willing to return in order that we may discuss with them the results of the routine laboratory work, or a sore knee, or that we may complete the physical examination. These reasons get them back to us in instances when they would balk at a return visit "just to talk."

Sam's mother was deeply worried because of his "terrible feelings of depression, his marked inferiority complex, and his inability to get along well with his companions." This sixteen-year-old boy's father and mother were divorced; the latter had custody of the children. Sam's elder brother had left college because of a severe emotional disturbance and his younger brother was said to have emotional difficulties.

At his first visit our patient was very suspicious, antagonistic, and extremely defensive. He said he had been told to stay out of sports and to wear a knee bandage. He talked about a variety of symptoms and expressed resentment at his restrictions from athletics. It was clear that he was confused and depressed and that he had unfortunate personality traits, but he was reluctant to return for any further visits. Sam denied, although he had been talking a great deal about his various difficulties, that he had any problems, and he refused to discuss them. He said he would not see a psychiatrist under any circumstances.

In the hope that on further acquaintance Sam's defensiveness would lessen, he was told that his knee condition was of sufficient importance to warrant attention and observation, and that it could be helped. He was willing to come back on this basis. On the subsequent four or five visits we ostensibly were concerned only with his mild Osgood-Schlatter's Disease, and cautiously helped him to gain some insight into his emotional difficulties. After a few visits Sam accepted a referral to a psychiatrist and is currently receiving treatment.

In a general practice clinic such as ours various physical aspects of illness as well as laboratory examinations can be used to have a patient return for successive visits in the hope that as a relationship to the physician develops it will later be possible to refer the patient to a psychiatrist. Some who need an expert's help but who, despite our efforts, refuse to see a psychiatrist, are willing to come in to see a "medical doctor." If this physician has the advantage of a psychiatrist's supervision, as he does in our Unit, he may be able to give support and treatment which is needed. While none would consider such a recourse ideal, it is obvious

that a physician trained in this way should be at least much better for this sort of patient than no treatment at all.

We all need to know more about adolescents. They are, after all, the adults of tomorrow, the inheritors of our civilization. Those who are now handicapped, or whose personalities and future effectiveness and happiness are threatened, have still the hope of change for the better. Later, and soon, that malleability, that capacity for change will be largely lost. Adolescence is the latest of the age periods in which we can expect success from other than the most expert and the most prolonged efforts to strengthen personalities or to build emotional or physical health. But not only those who brought troubles up from their early childhood and into adolescence now need and would benefit from understanding help. So, too, would those who waver and threaten to succumb to the conflicts, confusion, and stresses which the normal changes and events of adolescence put upon them. Clearly the better we understand these changes, the better we understand the nature and the kind of problems which beset these young people, the more effectively we can help them.

Some adults intuitively say and do just the thing that tips the balance in a troubled adolescent's favor, while others though better informed may fail to be of assistance. This, however, does not mean that a greater knowledge of adolescents is of little value. It does mean that knowledge *without feeling* may be useless. These young people are not yet independent—they are only striving to be; how you *feel* toward them, can be a greater factor than what you *know* about them. There is all the difference in the world between understanding *adolescence* and being interested in an adolescent. But an adult who is really interested in young people, and who feels genuinely sympathetic toward them, will be able to do more for them as he acquires a greater knowledge of their traits and needs and problems.


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## MEDICAL DEFENSE AND GRIEVANCE\*

CHARLES J. ASHWORTH, M.D.

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*The Author, Charles J. Ashworth, M.D., Past President, Rhode Island Medical Society; President, Rhode Island Medical Society Physicians Service.*

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THIS COMMITTEE of the Rhode Island Medical Society dates its origin back more than twenty-five years, one of the oldest among state medical societies. Its function recently has been broadened because of the widespread publicity given through many nationally circulated magazines to the laity, some of whom have published material, embellished with eye-catching headlines, to project the physician as an object of attack through county and state medical society grievance committees. This is pointed out for the purpose of emphasizing the twofold function of such committees as a basic objective.

One is to provide a means whereby any patient may have recourse to complain about the conduct of a case in the hands of an individual doctor. The other is to give the physician when complained against, sued, or threatened with suit, an opportunity to present and substantiate his part in the matter under dispute. This latter was the original purpose of our committee, but recent years have developed newer aspects of these differences between doctors and patients. We now hear both sides of some controversies before any legal action is started. In many instances, these cases are resolved satisfactorily by the committee, and most often on the basis of misunderstanding between the parties involved.

A difficult and not too infrequent situation arises when there is criticism by one doctor of another's handling of a case. So slight a gesture as raising one's eyebrows might be the basis for creating doubt in the mind of a patient about the treatment received by another physician. On the other extreme is the height of indiscretion for any doctor to remark: "Well, that's a poor result"; or the in between innuendo, "I wish I had seen you earlier." Without doubt, these remarks are not made with malicious intent, but by their very carelessness, plant a seed of dissatisfaction in the mind of the patient that often germinates subsequent action leading to suit.

A poor result, something less than was anticipated or desired by the patient, or the development of a complication never intended and much less designed by the doctor, is often the problem. In cases of this kind the question of carelessness on the doctor's part arises, or, the question as to whether he exercised the usual degree of skill recognized in the particular community.

Other causes for inviting malpractice action referred to grievance committees include:

- Lack of proper consent (especially minors)
- Poor or carelessly kept records
- Specific instructions
- Lack of coverage when absent
- Abandonment of a patient
- Responsibility for assistants
- Telephoned prescriptions
- Collection dangers and over charging
- Thinking out loud
- Guaranteeing success
- Bragging about or even admitting insurance coverage

While these causes may seem trivial, it becomes quite evident that many suits have resulted from the doctor's invitation through indiscretion in word or act, and carelessness.

These cases reach the committee through letters from the complainant, an attorney or insurance carrier, or the doctor. All pertinent information is obtained, and all parties involved are offered an opportunity to appear before the committee. The complaining person when so appearing has many times been made aware of some misunderstanding and the situation adjusted or the advice to adjust it with the doctor in question often followed.

When the doctor is or is about to be a defendant in a malpractice action, every conceivable fragment of evidence is secured and considered, the doctor invited with or without an attorney, to state his case, and the committee then assesses the facts to determine:

1. Is there negligence on his part?
2. Is the case defensible?
3. Has it only nuisance value?

One can readily understand that when the medical implications have been deliberated by the committee, legal opinion and other assistance is inevitably necessary in arriving at a decision or recommendation. These deliberations are made

---

\*Presented at the Annual Meeting of the Rhode Island Association of Medical Record Librarians, at Providence, Rhode Island, May 4, 1955.

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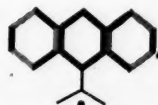
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# MEDICAL DEFENSE AND GRIEVANCE

*concluded from page 510*

during the doctor's absence from the room, but the results are communicated to him immediately, by word of mouth. Further action then depends upon subsequent developments.

The widespread existence and ever increasing number of grievance committees, called by other names in different localities, as professional conduct committee, patient-physician relationship boards, and others, materially extends the role of the practicing physician today. Being well schooled as well as adequately trained, he embraces not only those responsibilities inherited from previous generations of his profession, but also acquired obligations inseparable from the ever expanding and progressing development in the art and practice of medicine. From the very meager literature presently available, it is quite obvious that among the many possible reasons for complaints presented to these committees, two things every doctor has to be most careful about are: First, rendering each patient the very best care not only of which he is capable, but consistent with the standard of the community in which he practices; second, making charges neither inconsistent with the service and skill rendered, nor in excess of prevailing fees for the same or similar services; and, most important, not charging beyond the financial ability of the patient to pay.

Despite the general observance of these requisites, a doctor often finds himself charged with negligence when factors far beyond his control produce an undesired result. Medicine is not an exact science, and its practice therefore calls for the assumption of certain calculated risks that requires a degree of courage not demanded in most other professional fields. It is this type of exemplary physician that a committee defends in conjunction with his legal counsel and insurer without whitewashing. On the other hand, grievance and defense committees are acutely aware of a few individuals in the profession who through sharp

## RHODE ISLAND MEDICAL JOURNAL

practices and financial gouging make necessary such a source of appeal for the occasional victim of their unethical conduct.

The handling of complaints in this latter group, professional conduct, poses a more difficult problem. Some patients complaining of a professional service rendered may present a cosmetic defect or functional disability, and may already have been told by another doctor that the treatment was less than should have been expected, and thereby responsible for the result. When this type of complaint is dealt with, it is sometimes necessary to tell the complainant that although the disability is an actual fact, the attending doctor is not responsible for the poor result. When the reverse is true the doctor and his lawyer and insurance company are informed of the evidence of negligence.

Our committee in Rhode Island serves, we believe, a constructive purpose, the integrity of which has been maintained throughout the years, by not approaching any case with a preformed conclusion that the doctor is right. To foster the opinion that a committee was overly favorable to the doctor would injure the committee's reputation for competence and fairness, as well as the society's public relations, which in this era are pretty well herniated from repeated strains. But when the physician has fulfilled all the requirements and legal obligations due his patient, no suit should arise. When it does, it is usually successfully defensible, and the committee has the obligation to inform such a patient the blame and criticism cast upon the doctor is neither justified nor deserved and that medical authority is available to support this opinion.

We are all subject to the vagaries of human frailty, but none less than the M.D. There are many days when he is confronted with problems that make him wish he had stayed abed. No one, I am sure will dispute the fact that the great majority of doctors are conscientious, hard working and devoted individuals, only by whose courage and determination has the rest of humanity fallen heir to the present day excellence of health, the best ever enjoyed by any generation since the creation of man.

To perpetuate this legacy we need everybody's help—doctors, nurses, patients, hospital administrators, lawyers, and most certainly that of the record librarian.

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## PESTICIDES

### A Review of Current Literature

STANLEY SPRAGUE, M.D.

The Author, Stanley Sprague, M.D., of Pawtucket, Rhode Island, Chairman, Committee on Industrial Health of the Rhode Island Medical Society.

THERE APPEARS to be no question that the use of pesticides in agriculture has greatly increased production, and brought better food to the world. It is also noted that these pesticides must be used in a definite safe manner to protect the general public from the poisonous effects which these same pesticides can cause. Research is constantly going on in this regard both by government and private laboratories.

The estimate of insect damage to agriculture is estimated at an annual loss to the United States alone of four billion dollars, but fifty-two cents is returned for each dollar spent on insecticides. Gains in production, supply and storage of food will have beneficent action on human nutrition and health.

Opinions based on extensive research are to the effect that insecticides do not cause any diseases or increased susceptibility to disease in man or animals. In one area alone, workers exposed for a period of five years to DDT showed no evidence of physical damage attributable to DDT.

It is now possible to determine DDT intoxication in human beings by the excretion of a metabolite DDA in the urine. Previously, biopsy of the fat was the only available method.

As regards the phosphorus compounds, there is still evidence that fruit sprayed heavily with this compound remain toxic to experimental animals for many months.

Standardization of specifications of each pesticide is being put into effect and will make for safety, as all tests and precautions will be used before offering these products to the general public. Every new product (products are offered in greater number than can be tested) will in future have a sort of "Seal of Approval" before the public gets it.

More than eighty economic poisons have been reported on as of April, 1955. Each is treated from the chemical formula, physiological action, dangerous acute and chronic doses for man; signs and symptoms; laboratory findings; pathology; differ-

ential diagnosis to the actual treatment recommended for each. Copies of such a list are available at your Rhode Island Medical Society Library for your study. Also, it is hoped that each case will be reported to your Medical Society should your practice include a suspected case of poisoning from pesticides.

In handling any suspected case from pesticides a most careful history is of paramount importance. It is important to know what pesticide is suspected, what if any other poison was involved, concentration of the material, period of exposure, onset of symptoms and the symptoms presented. A careful neurological examination is also a "must," as many of the newer pesticides have a syndrome predominantly neurological. Some of the pesticides produce liver and kidney damage without signs pointing to those organs.

Treatment—mostly symptomatic, as many times exact poison causing symptoms is not known.

1. Emesis and gastric lavage (if poison is taken internally).
2. Evacuation of gut (avoid oily substances for these are not good if organic solvent or halogenated insecticide is involved).
3. Thorough washing of eyes and body if there has been external contact with the poison—the physician is advised to wear rubber gloves while aiding patient.
4. Supportive therapy
  - a. Sedatives—Sod. Pentobarb for acute poisoning because of its rapidity of action. Phenobarb used to maintain a prolonged level of sedation in persisting neural hyperexcitability or convulsions.
  - b. Stimulants—Adrenalin (in vascular collapse) used only after careful consideration; contraindicated when halogenated hydrocarbon insecticides, even though patient may be in severe depression or coma.
  - c. Transfusions—May be indicated except where pulmonary edema is already present. If blood not available, five per cent glucose or normal saline infusions indicated.
  - d. Oxygen therapy — Administered to patients with cyanosis or respiratory difficulty. Patients with pulmonary edema re-

quire oxygen under positive pressure as well as postural drainage and dehydration therapy until the exudate is checked.

If the nature of the toxic agent is known there may, of course, be an available specific antidote. Even so, the general care of the patient may do much to insure his survival.

The continued development of more insecticides is needed as in many areas the pests against which it is directed have produced an immunity to the previously used material. A volume of material has been written about so many various pesticides that it would take far more space than this or any other journal to even begin to condense data on each poison used, nor would it not have touched on the many Industrial Solvents which are constantly with those of us whose medical work takes them within this sphere.

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#### THE BEGINNINGS OF MEDICAL EDUCATION IN RHODE ISLAND—PART I

*concluded from page 502*

anxieties of commerce, the privations, discontents, and despair of poverty, and various other causes of mental perturbation, induce directly or indirectly, a large proportion of the diseases to which we have referred." In 1848 he reported in the American Journal of the Medical Sciences his cumulative surgical experience. This included fifteen herniotomies with eleven recoveries, one successful lithotomy, ligation of the common carotid artery, extirpation of the eyeball, a number of cataract extractions and other procedures. This largely antedated the discovery of ether, his only anaesthetics being laudanum and brandy. During 1831 he had a brief tenure as Professor of Obstetrics at Jefferson Medical College. This was an unsatisfactory experience and he did not repeat it. His fame in Providence rests largely on his successful endeavors in promoting the Rhode Island Hospital. I shall refer to these matters later. In 1853 he became first vice-president of the American Medical Association.

(to be continued)

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### RHODE ISLAND MEDICAL JOURNAL

#### DISTRICT MEDICAL SOCIETY MEETING NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was called to order by Robert L. Bestoso, President, on June 1, 1955 at the Hotel Viking at 8:30 P. M. with twenty-one members attending.

The speaker of the evening was Dr. Frank Cutts, President of the Rhode Island Medical Society. He enumerated the various committees of the Rhode Island Medical Society with their respective functions. He also spoke about the Physicians Service Plan with all its present economic difficulties and the protective devices that were being developed for protection of the Plan. A lively period of questions and answers followed his speech.

The minutes of the last meeting were read and approved.

The application of Dr. Barbara Veit to the Newport County Medical Society was read and her membership approved by the members of the Society.

A motion was made that the Secretary of the Society write to the Washington office of the A.M.A. and ask for a special report on the Bricker Amendment and that the item be placed on the Agenda of the Society. This was seconded and passed. Another motion was made that the Secretary request the Secretary of the State Society to forward a complete report on the various District Society balloting on Social Security. This was seconded and passed.

A motion was made that the study of Physicians office signs, advertising displays and listings be referred to the Public Relations Committee in order that it comply with the State Committee on Public Policy and Relations. This was seconded and passed.

A last motion was made that the President appoint a Liaison Committee to the Physicians Service consisting of three members of the County Society. This motion was seconded and passed.

Meeting adjourned at 10:05 P.M.

Respectfully submitted,  
José M. RAMOS, M.D., Secretary

\* \* \*

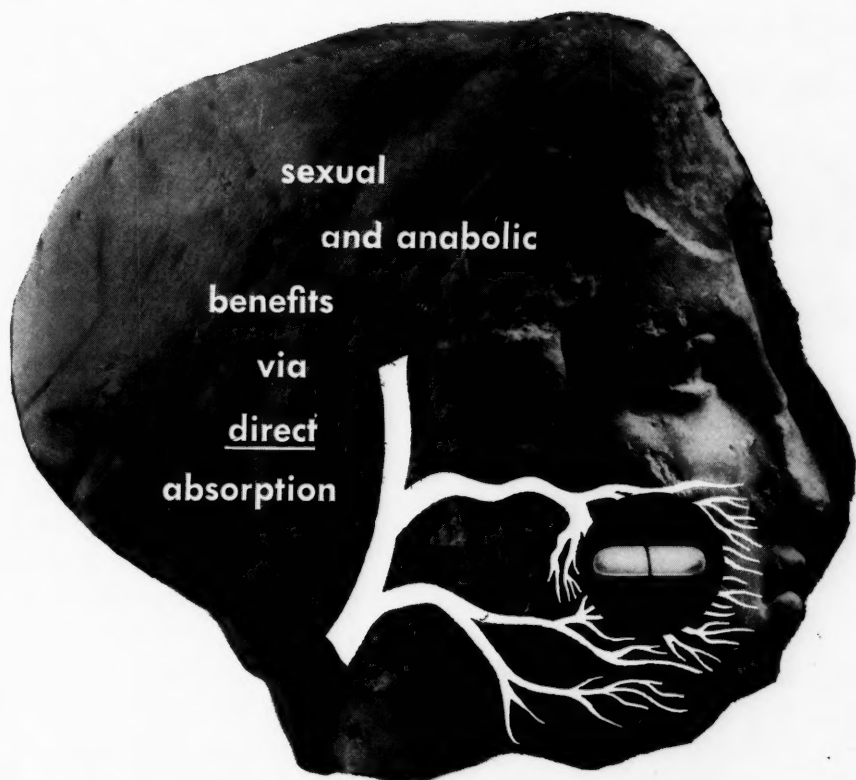
A special emergency meeting of the Newport County Medical Society was called to order by Dr. Robert Bestoso, president, at 9:00 P.M. at the Newport Hospital with twenty-four members attending.

This special meeting was called to order in order to clarify the misunderstanding concerning the status of the polio vaccine which was to be given on the following Wednesday to the school children of Newport.

Dr. Bestoso stated that he had been given clearance by Dr. McLaughlin of the State Board of

*concluded on page 518*





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## NEWPORT MEDICAL SOCIETY

*concluded from page 516*

Health that same afternoon, and was informed that the polio vaccine which was to be used in this city had been given six million children since last year with no untoward results.

Dr. MacLeod stated that there was no dispute going on concerning the safety of the vaccine to be used in this city, but rather a question in regard to its distribution. He stated that it was considered a safe procedure by the Newport Board of Health.

Dr. Adelson made a motion to approve administration of the polio vaccine. This was seconded by the society and passed.

Respectfully submitted,

José M. RAMOS, M.D., *Secretary*

## BOOK REVIEW

*THE REPRODUCTIVE SYSTEM* by Frank H. Netter, M.D. The Ciba Collection of Medical Illustrations, volume 2. Ciba Pharmaceutical Products, Inc., Summit, N. J. 1954. \$13.00

Frank H. Netter, M.D., physician, anatomist, and extraordinary medical artist has now completed his second full volume of illustrations. This volume comprises 270 pages of expert medical narration effectively punctuated by Dr. Netter's 235 superb illustrations.

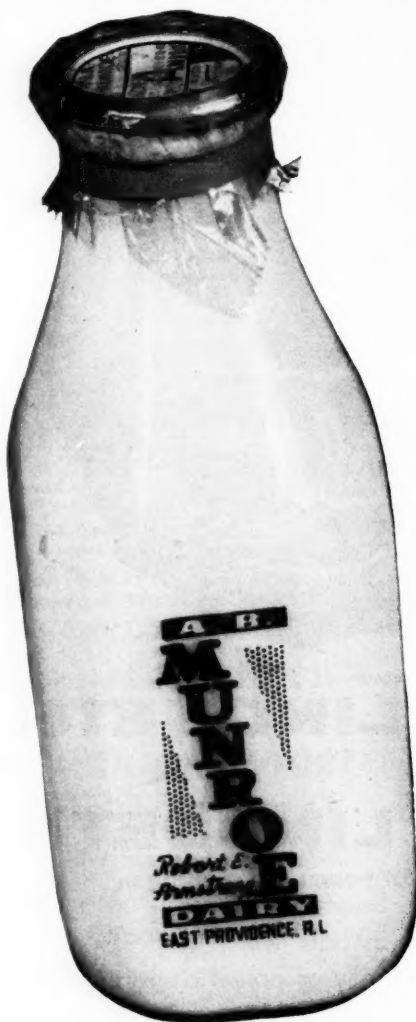
Dr. John Rock has written the foreword to this volume, and the following quote expresses very well the unique coverage of this book. "Interestingly, 75% of the pages handsomely portray pathology of both primary and secondary male and female sex organs; that is disorders in their form and function. This visual and verbal description of pathological conditions is of considerable clinical value. Moreover it aids effectively in the acquisition of the physiological knowledge we need so badly. Disorders in the growth and function of organs serve to define by distortion and magnification the factors involved in normal development and behavior."

This book should be a *must* in the library of every practicing urologist and obstetrician-gynecologist. Actually greater stress is directed toward the urological and gynecological problems, but both normal and abnormal obstetrical conditions are adequately covered and illustrated. It is divided into fourteen sections with an acknowledged authority writing the text. The first five sections are concerned with the male reproductive system, and sections six-fourteen deal with the female reproductive system.

As previously mentioned the illustrations are superb, the descriptive text authoritative, and the pathological descriptions accurate. Over and above this a brief suggestion as to therapy is also included

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1. Overall, J. C.: Southern M. J. 47:789, 1954.
2. Editorial: New England J. M. 246:111, 1952.
3. Grayzel, H. G., Heimer, C. B., and Grayzel R. W.: New York St. J. M. 53:2233, 1953.
4. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
5. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.
6. Turell, R.: New York St. J. M. 50:2282, 1950.

## ON THE MEDICAL LIBRARY BOOKSHELVES

### *Books Received*

The receipt of the following books is acknowledged and we thank the publishers for sending them. Unfortunately, not every volume received is reviewed either because of lack of space or because the reviewer to whom the book is assigned fails us.

Whether reviewed or not, the books are appreciated and are available at the Library.

The Adolescent Exceptional Child. A Realistic Approach to Treatment and Training. Proceedings of the 1954 Spring Conference of the Child Research Clinic of the Woods Schools held in New Orleans, Louisiana, April 9 and 10. Langhorne, Pa., 1954.

Collected Papers of the Mayo Clinic and the Mayo Foundation. Vol. XLVI, 1954. W. B. Saunders Company, Phil., 1955. \$12.50.

The foreword states that "the material for the present volume . . . has been selected primarily with the interests of the general practitioner, the general surgeon and the diagnostician in mind."

Beyond the Germ Theory. The Roles of Deprivation and Stress in Health and Disease. Iago Galdston, Editor. A New York Academy of Medicine Book. Health Education Council, N. Y., 1954. \$4.00.

Excerpta Medica. Section XVII. Public Health, Social Medicine and Hygiene. Vol. 1, no. 6. Amsterdam, 1955. Subscription \$16.00.

Section XVII was published for the first time in January of this year. Articles appearing in the RHODE ISLAND MEDICAL JOURNAL are abstracted frequently in the various sections of Excerpta Medica.

Handbook of Medical Treatment by Milton J. Chatton, Sheldon Margen and Henry D. Brainerd. Lange Medical Publications, Los Altos, Calif., 1954. \$3.00.

The 4th edition of the useful Handbook has been revised considerably and expanded in size.

The Medical Significance of Anxiety by Richard L. Jenkins, M.D. The Biological Sciences Foundation, Ltd., Wash., 1955. \$1.00.

Doctor Jenkins says "The practicing physician has no choice as to whether or not to deal with the

problem of anxiety. His only choice lies in whether he deals with it well or badly. This booklet is an endeavor to aid him to deal with it wisely."

New and Nonofficial Remedies 1955. Issued Under the Direction and Supervision of the Council on Pharmacy and Chemistry American Medical Association. J. B. Lippincott Co., Phil., 1955. \$3.35.

This important reference book provides our members with information on relatively new drugs.

Physical Examination of the Surgical Patient by J. Englebert Dunphy and Thomas W. Botsford. W. B. Saunders Co., Phil., 1953. \$7.50.

The publishers call this a "how to" book—*What* to look for, *how* to look for it and *what* your findings mean.

The Role of the Pituitary in Cancer. The Clinical Value of Pituitary Lipid Treatment by Henry K. Wachtel. The William-Frederick Press. N. Y., 1954. \$2.00.

Tea. A Symposium on the Pharmacology and the Physiologic and Psychologic Effects of Tea. Henry J. Klaunberg, Editor. The Biological Sciences Foundation, Ltd., Wash., 1955. \$1.00.

This is an interesting and enlightening discussion of a subject that has been written about throughout the ages. Tea, next to water, is the most consumed beverage in the world.

This Pace is *Not* Killing Us by J. I. Rodale. Rodale Books, Inc., Emmaus, Penn., 1954. \$1.00.

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Columbia University

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Members of the Inactive Reserve Corps will not be called to active duty without their consent except in time of grave national emergency at which time every individual will have a defense role to play, locally or nationally.

Since modern weapons have become so diversified protective measures against these newly developed weapons need to be similarly diverse. Therefore, special training courses are in the process of being developed. These courses will be used in the training of groups of inactive reserve officers, on a voluntary — expenses paid — basis, from time to time.

The Public Health Service is just as interested in recruiting general practitioners, internists, surgeons, and other clinical specialists for the Inactive Reserve Corps as it is in recruiting public health trained physicians. Attached is a descriptive pamphlet which tells more about the Inactive Reserve Corps.

It will be appreciated if you will call this recruitment program to the attention of the members of your Society. Anyone interested in receiving an application for the Inactive Reserve Corps of the Public Health Service may obtain one by writing to the: Surgeon General, U. S. Public Health Service, Washington 25, D. C.

Additional information may be obtained from: Regional Office, Department of Health, Education, and Welfare, 42 Broadway, New York 4, New York.

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Applicants are advised to report to the Industrial Relations Department, U.S. Naval Air Station, Quonset Point, R.I., for further details.

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## CANCER IN RHODE ISLAND IN 1954

### Annual Report of the Division of Cancer Control of the Rhode Island State Department of Health

THOMAS H. MURPHY, M.D.

The Author, *Thomas H. Murphy, M.D., Medical Director, Division of Cancer Control, Rhode Island State Department of Health.*

THE STATISTICS compiled by the Division of Cancer Control for 1954 reveal 416 more new cases reported than in 1953. In 1953 there were 1,943 new cases; in 1954 there were 2,359 new cases reported.

This may not represent an actual increase because the reporting was much better in 1954. The majority of the reports are sent in by hospitals where the patients are treated. Few cases are reported that are treated at home or in physicians' offices.

Physicians are reminded that cancer is a reportable disease and forms may be obtained at the Division of Cancer Control in the State Office Building.

The number of cancer deaths reported in 1954 was 1,432 compared to 1,339 in 1953. This is an increase of 93. The continued increase in the number of new cases and deaths proves to the medical profession that in spite of advances in many fields, cancer is still a baffling problem. The available weapons: surgery, X ray and radium are limited in their scope unless an early diagnosis is made before metastasis has taken place. The majority of cases reported from hospitals indicate that metastatic lesions were present at the time of initial treatment. Thus, we are reminded that the only hope for the majority of cancer victims is early diagnosis.

We must continue to urge people to have health examinations at least once each year in order to

diagnose more cancer cases before they present symptoms. Let us continue the slogan "Every physician's office a Cancer Detection Center."

**TABLE II**  
*Analysis of Cancer by Age Group*  
— 1954 —

Age Groups	Males	Females	Total
0 to 9 .....	8	3	11
10 to 19 .....	15	6	21
20 to 29 .....	21	33	54
30 to 39 .....	40	88	128
40 to 49 .....	87	192	279
50 to 59 .....	219	289	503
60 to 69 .....	332	344	676
70 to 79 .....	274	229	503
80 to 89 .....	80	78	158
90 to 99 .....	9	5	14
Not stated .....	2	4	6
<b>TOTAL .....</b>	<b>1088</b>	<b>1271</b>	<b>2359</b>

**TABLE IV**  
*Rhode Island Cancer Deaths by Age Groups, 1954*

Age	M	F	Total
1-9 .....	5	6	11
10-19 .....	8	2	10
20-29 .....	3	2	5
30-39 .....	25	19	44
40-49 .....	55	60	115
50-59 .....	123	121	244
60-69 .....	242	198	440
70-79 .....	214	173	387
80-89 .....	85	75	160
90-99 .....	9	7	16
<b>TOTAL .....</b>	<b>769</b>	<b>663</b>	<b>1432</b>

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TABLE I  
*Analysis of Cancer by Primary Site and Sex*  
 — 1954 —

Primary Site	Male	Female	Total
Lip	18	3	21
Tongue	13	2	15
Mixed Salivary Gland Tumor (mal.)	2		2
Sublingual Gland	3	8	11
Floor of Mouth	10	2	12
Other parts of mouth, unspecified	8	1	9
Oral Mesopharynx	7		7
Nasopharynx	2	2	4
Hypopharynx	1	1	2
Pharynx, unspecified	3	1	4
Malignant Lymphoma	4	1	5
Esophagus	13	4	17
Stomach	83	51	134
Small Intestine	3	3	6
Large Intestine	143	143	286
Rectum	66	62	128
Biliary Passages and Liver	16	28	44
Pancreas	27	17	44
Peritoneum		2	2
Nose, Nasal Cavities and Accessory Sinuses	1	1	2
Larynx	26	2	28
Bronchus and Lung, primary	103	28	131
Bronchus and Lung, unspecified	1	2	3
Mediastinum	3	3	6
Breast	9	335	344
Cervix Uteri		111	111
Corpus Uterus		120	120
Chorionepithelioma		1	1
Ovary, Fallopian Tube and Broad Ligament		75	75
Unspecified Female Genital Organs		19	19
Prostate	157		157
Testes	10		10
Unspecified Male Genital Organs	6		6
Kidney	16	10	26
Bladder and Other Urinary Organs	77	24	101
Skin	122	86	208
Eyes	2	2	4
Brain and Other Parts of C.N.S.	7	11	18
Thyroid Gland	7	12	19
Adrenal Gland	1		1
Bone	9	8	17
Lymph Nodes (unspecified whether primary or secondary)	26	14	40
Unspecified Sites Reported as Carcinomatosis	37	45	82
Lymphosarcoma	1		1
Other Primary Lymphoid Tissue		2	2
Malignant Lymphoma	5	2	7
Hodgkin's Disease	19	6	25
Reticulosis	2		2
Lymphatic Leukemia	16	13	29
Acute Myeloid Leukemia	3	3	6
Acute Leukemia, unspecified type	2	1	3
Total	1088	1271	2359

1953-1943

New cases

Increase 416

continued on next page

